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Solicitation Information
March 25, 2014

ADDENDUM # 1

LOI# 7548558

LOI Title: DENTAL HEALTH PLAN(S) FOR RITE SMILES PROGRAM

Bid Opening Date & Time: Monday, April 7, 2014 at 10:30 AM (Eastern Time)

Notice to Vendors:

ATTACHED ARE VENDOR QUESTIONS WITH STATE RESPONSES.

NO FURTHER QUESTIONS WILL BE ANSWERED.

David J. Francis
Interdepartmental Project Manager

Interested parties should monitor this website, on a regular basis, for any additional information that may be posted.

Vendor Questions for LOI #7548558 DENTAL HEALTH PLAN(S) FOR RIte SMILES PROGRAM

Question 1: Will the contract be awarded to just one Contractor, or can the contract be split among multiple Contractors? If the contact will be awarded to multiple Contractors, is the number of Contractors defined or situational dependent upon number of qualified submitters?

Answer to question 1:

The State reserves the right to award this contract to one or multiple vendors, based on the strength of the bids.

Question 2: If the contract is awarded to multiple Contractors, will there be an initial and ongoing annual re-enrollment requirement to allow enrollees choice in DBM Plan?

Answer to question 2:

If more than one vendor is selected, the State will have an 'open enrollment' period to allow each member to choose a plan. Members that do not choose a plan will be auto-assigned based on an algorithm determined by the State. If more than one vendor is selected, we anticipate that open enrollment period will occur in early Fall 2014.

Question 3: According to the Rite Smiles Data Book report, capitation rates were developed assuming one DBM Contractor. If multiple DBM Contractors are servicing the contract the capitation rates will not be appropriate unless each contractor enrolls the same distribution of enrollees in each age group. Therefore, the capitation rates will need to be "re-calibrated".
Please confirm that such appropriate adjustments to the capitation rates will be made.

Answer to question 3:

If more than one vendor is selected, the State will revisit the rate setting process.

Question 4: Is attached DBP Fee Schedule as of 01/10/2011. Since the capitation rate was developed using United's claim information, please confirm that this Fee Schedule is the most current active Schedule? If not, can the current schedule be provided?

Is the fee schedule referenced above the only fee schedule used for the program? If not, can other fee schedules be provided?

Answer to question 4:

The document that was referenced in this question was not published by the State. Capitation rates were established based on historical utilization, not on a fee schedule. See RIte Smiles Data Book in the Procurement Library.

Question 5: What is the reimbursement methodology used by Rite Smiles for FQHC's and hospital based clinics? It is our understanding that they are paid an "encounter fee" basis as well as a payment for the procedures performed (CDT). If so, what are the approved encounter fees and were these fees included in the claims experience needed to calculate the capitated rates? If not, will an adjustment be made to the capitated rates to reflect these additional costs?

Answer to question 5:

In the State of Rhode Island, the FQHCs are enrolled in the State's Dental Benefit Plan (DBP); claims for services are sent to the DBP and paid according to the DBP fee schedule. For dental services, the provider bills the State separately to be reimbursed for the difference between the value of the payment received from the DBP and the value of the State-determined encounter rate, much like billing to a 'secondary' payer. The State utilizes historical cost data for these projections. However, the DBP must reimburse the FQHCs in accordance with the fees paid to other providers for a similar service (See response to Question 29).

Question 6: Is there a minimum point score that must be obtained to be eligible for award of the contract?

Answer to question 6:

All applications will be evaluated by scoring each category that is outlined in the LOI. Applications must demonstrate strength in each category in order to be considered. There is no minimum score for eligibility; all applications will be thoroughly reviewed for compliance to all requirements set forth in the LOI. Additionally, for all Pass/Fail criteria, the applicant must receive a "Pass" in order to be considered.

Question 7: Under the definition of Medically Necessary Care, can the current definition of Medically Necessary Orthodontia (MNO) and approved by OHIC apply under this contract? If not, must the currently used scoring methodology for MNO also apply? Delta Dental of RI uses nationally recognized and well established policies and procedures as guidelines to determine medical necessity. Please verify our expectation that these policies can continue to be used to further define medical necessity based on these accepted standards.

Answer to question 7:

The State relies on standards set in the HDL scoring index to determine definitions for Medically Necessary Care. More information can be found in the Procurement Library.

Question 8: Please confirm the total number of Complaints, Grievances and Appeals totaled 16 for the prior plan year as reported by the current DBM contractor.

Answer to question 8:

All information that the State is able to share on Complaints, Grievances, and Appeals is documented in the Procurement Library.

Question 9: Please confirm that out of network providers that treat Medicaid patients are held to the Medicaid allowance as payment in full.

Answer to question 9:

No provider is allowed to 'balance bill' the member. All rates paid are based on the contractual rates established by the DBP in which the RIte Smiles member is enrolled. Out of Network providers who treat RIteSmiles enrollees are required to recognize any receipt of Medicaid dollars as payment in full for that service.

Question 10: In addition to either accept/reject newly added eligibility groups does the opportunity exist to renegotiate capitation fees based on new group demographics and forecasted utilization patterns? How are new eligibility groups assigned to a plan if multiple DBM contractors exist under this contract?

Answer to question 10:

If new eligibility groups are added to the RIte Smiles program, the State will determine whether the characteristics of the new groups are significantly different from existing eligibility groups so as to warrant a revision to the capitation rates.

In the event of multiple venders, members of any new RIte Smiles eligibility group will be offered an opportunity to choose a plan.

Question 11: Please confirm the criteria for the reassignment of eligibility

Answer to question 11:

Only the State can determine eligibility. Eligibility determination occurs under the new Federal Medicaid rules, MAGI. This is re-determined every 12 months.

Question 12: Please provide copies of all currently approved marketing materials and Member Handbook in all currently required languages. If these cannot be provided, what languages other than English are materials translated into?

Answer to question 12:

If 50 or more people in the network speak a language other than English, all materials must be translated into that language. All materials that the State is able to share are documented in the Procurement Library.

Question 13: Please provide the dollar value of claims paid for behavioral issues.

Answer to question 13:

The dental expenditures for ADA Code D9920 Behavior Management are included in the RIte Smiles Data Book for each age group under the "Adjunctive" Service Category.

Question 14: Does the option of a second opinion apply to all services or is it limited to major restorative services and oral surgery?

Answer to question 14:

All RIte Smiles members are entitled to a second opinion for any type of service. In practice, members usually request this for major restorative services and oral surgery.

Question 15: Please provide a list of all School Based Clinics and approved Mobile Clinics. Also confirm these entities are paid according the attached fee schedule.

Answer to question 15:

Many of the school based clinics are organized by FQHC's and St. Joseph Hospital. EOHHS does not publish information on this and cannot comment on the fee schedule as we do not publish this information.

Question 16: Please provide copies of previously submitted quarterly grievance and appeals report.

Answer to question 16:

Templates are attached. See Attachment I & II Appeals Template and Grievance Template.

Question 17: Please provide copies of previously submitted member and provider satisfaction reports.

Answer to question 17:

Templates are under development and will be reviewed with successful bidder(s).

Question 18: Please provide copies of previously submitted fraud and abuse reports.

Answer to question 18:

Templates are attached. See Attachment III Fraud and Abuse Investigation Report.

Question 19: Are EOB sampling guidelines established regarding sampling size?

Answer to question 19:

More information is needed to answer this question. For RIte Care, the EOMB sampling frame is 10 percent of paid claims per month, based on a sampling algorithm that must be pre- approved by the State.

Question 20: As a not for profit dental insurance Company exceeding the necessary State mandated reserve requirements, we do not believe we are subject to reinsurance requirements. Please validate this assumption.

Answer to question 20:

Please refer back to the LOI for information on reinsurance requirements.

Question 21: Does a defined list of procedures considered experimental or investigational exist? If so, can the list be provided?

Answer to question 21:

No, Medicaid does not have such a list. The State reserves the right to add a list at any time.

Question 22: The RFP requires that fees paid for certain procedures (D0120, D1120, D1206, D1208) be paid at 90% of prevailing commercial rates in RI. However, the fees for these codes on the attached fee schedule are significantly below that required level.

Will the contractor be required to pay at the specified level stated in the contract or will contractors be permitted to pay at the level of the incumbent contractor?
If payments must be made at the higher fee level please confirm the capitation rates will be adjusted accordingly.

Answer to question 22

The document that was referenced in this question was not published by the State. All conditions set in the RFP regarding the payment of procedures at 90% of the commercial rates are valid.

Question 23:
Subcontract Specification- Will EOHHS allow a Medicaid health plan to be the Bidder (lead contractor) with a DBM subcontractor?

Answer to question 23:

The State is interested in reviewing all types of contracting models. The State will review all submitted applications.

Question 24:
Enrollment- If the State selects more than one DBM to the RIte Smiles Program:

a. How will these new dental plans be assigned membership?
b. Will the existing United HealthCare's RIte Smiles membership be re-assigned to a new dental plan?
c. Will EOHHS consider assigning Rite Smile members to align with enrollment in their Rite Care health plan?
d. Will EOHHS re-assign current RIte Smiles enrollees according to their RIte Care health plan enrollment?

Answer to question 24:

a) If more than one vendor is selected, the State will offer an open enrollment period.
b) If more than one vendor is selected, the State anticipates offering an 'open enrollment' period.
c) This will depend on the outcome of the procurement. The State will address this at a later date.
d) This will depend on the outcome of the procurement. The State will address this at a later date.

Question 25:

Licensure & QA Requirements

Section 3.1 Dental Plan(s) Licensure and Organizational Requirements (pages 12-13) states "the entity providing the dental management expertise is a separate corporation (e.g., a subsidiary of the Bidder or a subcontractor to which delegation to be made), then the Bidder assures that entity meets the foregoing (Rhode Island licensure) requirements.

a. Does this apply to a vendor licensed in another state that the Bidder plans to subcontract must hold a Rhode Island license at the time the LOI is submitted? Can the subcontractor be licensed by the time of implementation?

b. Section 3.1 further states "The Contractor will become accredited in Rhode Island as a Dental Plan within 12 months…" Does this apply to the Bidder only, or also the Bidder's subcontractor?

Answer to question 25:

a) Please refer to the LOI. Yes, a subcontractor can be licensed by the time of implementation.
b) Currently, there is no accreditation process for the State of RI. If this becomes available, both the Bidder and their subcontractor must complete the accreditation process within 12 months.

Question 26:

Licensure & QA Requirements -Section 3.9.1 Dental Director states that "The Dental Director need not serve full-time nor be a salaried employee of the Bidder, but the Bidder must demonstrate that it is capable of meeting all requirements using a part-time or non-employed Dental Director."

a. Will a Dental Director who is housed in the DBM subcontractor's organization meet this requirement?

b. Is the Dental Director (Rhode Island licensed) required to have Rhode Island residency?

c.

Answer to question 26:

a) Yes
b) No

Question 27:

Capitation Rate Methodology

If the state selected more than one bidder, it is likely that one of the plans may have more children enrollees in the 10-14 age category while the other plan has more children aged 0-9. In such case, will EOHHS apply two different age-based rates? See page 2 of the RIte Smiles Dental Capitation Rate Certification Letter, Feb. 21, 2014 (from EOHHS Procurement Library). The letter states that "*We examined the possibility of maintaining 2 rate cells, one for children aged 0-9 and another for children aged 10-14, as orthodontia services account for an increased portion of the total expenses in this latter age group. We concluded that it would be administratively simpler to maintain a single capitation rate since there is currently only one carrier participating in the program.*"

Answer to question 27:

A single rate was set for one vendor. If multiple vendors are chosen, the rates will need to be revisited.

Question 28:

Capitation Rate Methodology

Page 3 of the same certification letter states *"The data for children aged birth to 11 were blended by placing 70% credibility on the most recent year and 30% on the previous year. The data for children age 12 were blended by placing 60% credibility on the encounter data for the most recent period and 40% on the FFS data from the previous period. The data for children ages 13 and 14 were blended by placing 75% credibility on the most recent period, 20% credibility on the next most recent period and 5% on the oldest period."* Referencing this certification letter to RIte Smiles Data Book of Feb. 21, 2014 (tables on pages 14, 15 and 17), we raise the question as why is the utilization/1000 significantly less for most of all FFS service categories as compared to most of all DBM service categories. Can EOHHS provide the detail behind the managed care adjustments? Is the adjustment an increase or decrease?

Answer to question 28:

Historically, there has been an observed difference in utilization rates between managed care and fee-for-service in the State's dental experience. This is in part due to differences in emphasis on the types of services provided in managed care vs. fee-for-service, and in part due to different needs as children get older and establish longevity in the managed care program. The managed care adjustments, as applied to the fee-for-service experience, include increases and decreases depending on the service category under consideration. For example, in anticipation of greater emphasis placed on preventive and diagnostic services under a managed care environment, the managed care adjustments reflect an increase in utilization for those service categories over the fee-for-service experience. Conversely, for Periodontics services the managed care adjustment reflects a reduction in utilization over the fee-for-service experience. The managed care adjustments also reflect the changing needs of the older children as the program matures, as existing RIte Smiles members age-in and newly eligible older children enroll into the program.

Question 29:
FQHC utilization is not included in the historical utilization to calculate a base rate. Since the plan will be paying FQHC dental claims, shouldn't the FQHC utilization be reflected in EOHHS's rate?

Answer to question 29:

The State expects that FQHCs will be paid by the RIte Smiles Contractor at rates no lower than the rates paid by the Contractor to other providers for similar services. The provider will bill the State directly in order to be paid the difference between the value of the payment received from the DBP and the value of the State determined encounter rate for dental services, similar to 'secondary' or 'balance billing'.

Question 30:
Capitation Rate Methodology
Please explain the FQHC payment requirement, is the DBM allowed to reimburse the FQHCs cost-based payments? Please provide the FQHC cost-based rates.

Answer to question 30:

The State expects that FQHCs will be paid by the RIte Smiles Contractor at rates no lower than the rates paid by the Contractor to other providers for similar services. The provider will bill the State directly in order to be paid the difference between the value of the payment received from the DBP and the value of the State determined encounter rate for dental services, similar to 'secondary' or 'balance billing'.

Question 31:

Capitation Rate Methodology

Risk share arrangement – please restate how EOHHS will administer the risk share requirement.

Answer to question 31:

The Risk/Gain Sharing methodology is outlined in Attachment G of the Model Contract. The contractor is expected to send to the State a report of cumulative claims expenses each month during a contract period and for an additional 12 month following the close of the contract period. The report will reflect cash values as well as IBNR values. The additional twelve month period allows for run-out of IBNR. Once the run-out period has lapsed, the State will use encounter data to assess the reasonableness of the value reported by the Contractor of the paid claims reported on the risk share schedule. If the State can come within one percent of the value claimed by the Contractor, the State will finalize the settlement and either pay to the Contractor a Risk Share settlement or recoup from the Contractor a Gain Share settlement.

If the State does not come within one percent of the value reported by

Question 32:

Instead of a stand-alone DBM, will EOHHS consider embedding pediatric dental benefits in the RIte Care health plan?

Answer to question 32:

No, not at this time.

Question 33: Can EOHHS provide the Rite Smiles Provider Directory?

Answer to question 33:

All information that we are able to share is documented in the Procurement Library.

Question 34: Section 3.6 Service Accessibility Standards—please clarify the statement "bidder is not responsible for emergency medical or dental conditions." Are these only the services listed in Attachment B?

Answer to question 34:

The following services will be paid for by existing Medicaid fee-for-service system, or on a contractual basis by the Department: (1) Services to diagnose and treat an Emergency Dental Condition in an inpatient hospital setting, or (2) Services to diagnose and treat an Emergency Dental Condition in a hospital emergency department. In addition, the oral surgery services in ATTACHMENT B are considered "medical" and will be paid for under the existing Medicaid fee-for-service system or on a contractual basis by the Department.

Question 35: Section 6: Proposal Submission. On page 36, item 3 of Response Contents limits technical proposal to six (6) pages, excluding appendices. However, in the Proposal Specification Summary Checklist (on page 35), the suggested number of pages for the Technical Proposal Elements add up to 40 to 42 pages (9 to 11 pages for Experience and Understanding; and 31 pages for Technical Response Plans). Please clarify the exact page limit for the technical proposal.

Answer to question 35:

The page limit is 40 pages.

Question 36: When will the State respond to the LOI/RFP questions submitted herein? Given the time-sensitivity of LOI submission, will the State consider extending the proposal deadline beyond April 7, 2014?

Answer to question 36:

No, the State does not anticipate extending the submission deadline past 4/7/14, but reserves the right to do so should circumstances warrant an extension.

Attachment I (in response to Question 16)
Appeal Template

	A	B	C	D	E	F	G	H
1	MEMBER ID	DESCRIPTION	ISSUE TYPE (1st, 2nd, or 3rd (Ext.) Level).	DATE RECEIVED	DATE SENT	OUTCOME	GROUP/LOB	CLINICAL OR ADMIN
2								
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RIte Smiles

Attachment II (in response to Question 16)
Grievance Template

	A	B	C	D	E	F	G
1	CASE NUMBER	DESCRIPTION	ISSUE TYPE	DATE RECEIVED	DATE COMPLETE	UPHELD	CLINICAL/ADMIN
2							
3							
4							
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28							
29							
30							
31							
32							

RIte Smiles

Attachment III (in response to Question 18)
Fraud and Abuse Investigation Report

Name of Health Plan:									
Contact Person's Name & Telephone Number:									
Date of Report:									
	Case Name:	**Provider or Vendor Type (a):**	**Place of Service (b):**	**Reason(s) for Plan's Initiating Internal Review (c):**	**Date Opened for Internal Review by the Plan (d):**	**Findings from Plan's Internal Review (e):**	**Date Case Was Sent to RI DHS & RI DAG (f):**	**Estimated Dollar Loss (g):**	**Date That Written Request Was Sent to DHS to Seek Recovery of Funds & Amount Requested (h):**
A.	**Open Provider/Vendor Cases:**								
1	**Name:** / **Medicaid IDN (or NPI #):**								
2	**Name:** / **Medicaid IDN (or NPI #):**								
3	**Name:** / **Medicaid IDN (or NPI #):**								
4	**Name:** / **Medicaid IDN (or NPI #):**								
B.	**Closed Provider/Vendor Cases:**								
1	**Name:** / **Medicaid IDN (or NPI #):**								
2	**Name:** / **Medicaid IDN (or NPI #):**								
3	**Name:** / **Medicaid IDN (or NPI #):**								
4	**Name:** / **Medicaid IDN (or NPI #):**								

Legend:

(a) = Enter Provider or Vendor Type: Ambulance/Transportation; Clinical Laboratory; Community Mental Health Center; DME Vendor; FQHC; Home Health; Hospital; Imaging/X-ray; Nursing Home; Other (specify); Pharmacy; Physician (or other Licensed Independent Provider); Residential Treatment Facilities; Substance Abuse Treatment Facility

(b) = Enter the relevant numeric Place of Service code (Field 24B - CMS 1500 form) - These are listed on the following page.

(c) = Enter reason(s) for initiating an internal investigation. Examples are listed on the following page.

(d) = Enter this date as MM/DD/YYYY.

(e) = Enter a brief description of the Plan's findings (or indicate that the investigation is on-going).

(f) = Any case of suspected fraud/abuse must be sent to the RI DHS Fraud Unit & the RI Dept. of the Attorney General, Medicaid Fraud Unit for further action within five (5) business days of a health plan's conclusion of its initial investigation.

(g) = Enter an estimate of the potential dollar loss associated with this case.

(h) = Written notification must be sent by a health plan to the RI Department of Human Services Fraud Unit within five (5) business days of a health plan's intent to recover funds pursuant to fraud and abuse investigations outcomes, and approval must be obtained from the Department prior to collection of those funds. Enter this date as MM/DD/YYYY. Also, enter the dollar amount requested for recovery.

(b) Place of Service Codes:

Code:	Definition:
00	Pharmacy
03	School
04	Homeless Shelter
08	Tribal 638 Provider Based Facility
11	Office
12	Home
13	Assisted Living Facility
14	Group Home
15	Mobile Unit
20	Urgent Care Facility
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room, Hospital
24	Ambulatory Surgical Center
25	Birthing Center
26	Military Treatment Facility
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
41	Ambulance, Land
42	Ambulance, Air or Water
49	Independent Clinic
50	Federally Qualified Health Center
51	Inpatient Psychiatric Facility
52	Psychiatric Facility Partial Hospitalization
53	Community Mental Health Center
54	Intermediate Care Facility/Mental Retardation
55	Residential Substance Abuse Treatment Facility
56	Psychiatric Residential Treatment Center
57	Non-Resident Substance Abuse Treatment Facility
61	Comprehensive Inpatient Rehabilitation Facility
62	Comprehensive Outpatient Rehabilitation Facility
65	End-state Renal Disease Treatment Facility
71	State or Local Public Health
72	Rural Health Clinic
81	Independent Laboratory
82	Court
83	Correctional Facility
84	Other Community Setting
85	Drop-in Center
86	Foster Home
87	Place of Employment
99	Other Place of Service

(c) = Examples of Reasons for Initiating an Internal Investigation:

A. Submitting claims for services that were not provided.
B. Misrepresentation of patient information to receive services or reimbursement.
C. Provider billed for services after license was suspended or revoked by the State.
D. Prior conviction for fraud.
E. Falsification/alteration of claims or records.
F. Duplicate billing.
G. Billing for multiple components of a product or service that should have been included in a single fee (unbundling).
H. Billing for a more expensive service than the one that was actually provided (upcoding).
I. Billing for ancillary, therapeutic, or other services that require a physician's order, which was not obtained.
J. Billing-related complaint from an enrollee.
K. Billing by a provider who has been excluded from participation in Federal healthcare programs by the US DHHS OIG.
L. Billing for a vaccine product that was obtained free of charge from a State or Federal vaccine distribution program.